August 12, 2024

ERISA Advisory Council
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, DC 20210

Dear Members of the ERISA Advisory Council,

On behalf of the thousands of patients that we have supported since our founding in 2003, I am writing to share our experiences and insights in assisting patients and their families with appealing insurance denials. In our roles as advocates for our patients, Guardian Nurses work tirelessly to ensure that they receive the healthcare benefits to which they are entitled under their insurance plans, including those governed by the Employee Retirement Income Security Act (ERISA).

We are hired by private companies, health insurance brokers, Taft-Hartley health and welfare funds, as well as private individuals and families. Because of this client roster, the majority of our patients are insured either by commercial insurance (Aetna, Blue Cross, et al) or by Medicare. The few cases we have supported where patients were on Medicaid has been pro bono. Regardless of the insurer, the referrals we receive from our clients frequently involve navigating the complex landscape of insurance denials and appeals. Since 2003, our records show that we have been referred 6,194 patients, engaged 90% of those, and quite proudly, have 'won' 93% of those cases. We estimate that those 'wins' translated into over $1 million in savings.

Much has been written about patients' frustrations and anger when interacting with the American healthcare system and because of the nature of our work, we see it every single day. Most notably, the Kaiser Family Foundation has written extensively on the universal difficulties that consumers face dealing with their health insurance benefits and coverages. Last year, the Foundation published a survey of Consumer Experiences with Health Insurance (June 2023) which highlighted several key aspects of how people interact with their health insurance. They included cost concerns, access to care, plan complexity, customer service, and mental health. We can say with confidence that Guardian Nurses has experience and success in supporting all of these.

Patients often face denials for necessary medical treatments, medications, or services, which can be daunting and stressful. Guardian Nurses provide critical support to these individuals by:

1. **Reviewing Denial Letters and Policies:** We meticulously review the denial letters issued by insurance companies and cross-reference them with the patients' insurance policies. This process helps us understand the grounds for denial and identify any potential discrepancies or unjust denials.



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2. **Gathering and Organizing Medical Evidence:** To support appeals, Guardian Nurses collect and organize medical records, doctor's notes, and other relevant documentation. This evidence is crucial in demonstrating the medical necessity of the denied treatment or service.

3. **Writing Appeal Letters:** Our team assists in drafting detailed and well-supported appeal letters to insurance companies. These letters address the reasons for denial, provide supporting evidence, and make a strong case for overturning the denial based on medical necessity, policy language, and regulatory requirements.

4. **Navigating the Appeals Process:** We guide patients through the multi-step appeals process, which often includes internal appeals and external reviews. Our goal is to ensure that patients are fully informed and supported at every stage.

5. **Providing Emotional Support:** Beyond the technical aspects, we offer emotional support to patients and their families. The stress and anxiety associated with healthcare denials can be overwhelming, and having a knowledgeable advocate can make a significant difference.

Through our 20 years of doing this work, we have identified several systemic issues that often hinder patients' access to necessary care. These include unclear policy language, inconsistent application of medical necessity criteria, and unnecessary (and sometimes intentional) delays in the appeals process. Many times, the denials, and often, peer-to-peer reviews, are done by physicians who have no expertise in the medical condition related to the claim. We've had gastrointestinal physicians deny breast cancer genetic tests, for example. This just adds to the delays and the frustration.

We believe that addressing these issues at the regulatory level could improve patients' experiences and outcomes. The foundation of having success is educating consumers about their health insurance, what it covers, how it works, definitions of important components of their plan like in-network versus out-of-network, co-pay versus deductible, and others.

We respectfully urge the ERISA Advisory Council to consider the following recommendations:

1. **Enhance Transparency and Clarity in Insurance Policies:** Require insurers to write clearer and more accessible explanations of coverage and exclusions in policies to help patients understand their rights and benefits. Test the insurer's materials with 'average working people' and if they can't understand what's being written, require insurance companies to edit until they do.

2. **Standardize Medical Necessity Criteria:** Develop standardized criteria for determining medical necessity to ensure consistent decision-making across insurance companies. Require insurers to share the reasons for their decision based on the clinical indication, whether the test or procedure is appropriate and evidence-based. Studies have shown that around 40-50% of health insurance denials are overturned on appeal. This percentage can vary depending on the insurance company, the nature of the claim, and the persistence of the policyholder in pursuing the appeal.



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3. **Streamline the Appeals Process:** Simplify and expedite the appeals process to reduce delays and administrative burdens on patients and healthcare providers. Require that physicians who review the case have a clinical expertise in the case. Create a maximum time period that an appeal can go without a decision and establish stricter oversight and penalties for insurers who unnecessarily delay decision making.

4. **Create a Nurse-Led Department within the Department of Labor to support patient complaints.** This department would be staffed by experienced nurse case managers who understand the challenges for patients to receive necessary, appropriate care that is covered. Empowered by the Department of Labor, patients would be encouraged to utilize this department to investigate customer service problems when dealing with insurers, unclear language in summaries of plan benefits,

5. **Increase Accountability for Insurers:** Implement stricter oversight and penalties for insurance companies that routinely deny medically necessary care.

Guardian Nurses are passionate about advocating for patients' rights and ensuring they receive the healthcare they need. We appreciate the Council's efforts to improve the ERISA-governed benefits landscape and welcome the opportunity to provide further insights or participate in discussions on this important issue.

Thank you for your attention to this matter.

Sincerely,

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